39 Rittenhouse Pl
Ardmore, PA 19003
(610) 642-8837

1410 Russell Rd, Suite 201
Paoli, PA 19301
(610) 644-6501

797 E. Lancaster Ave., #9
Downingtown, PA 19335
(610) 873-0322

1324 MacDade Blvd.
Woodlyn, PA 19094
(484) 480-4509

Eric Ricefield, D.P.M. Mark Yagodich, D.P.M. Aliza Eisen, D.P.M.

Authorization And Release

- I authorize any holder of medical information about me to release this information to my insurance company or its intermediaries or carriers, or to this physician's office.
- I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Your Next Step, PC. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.
- I understand that I am financially responsible for all charges whether or not paid by my said insurance.

Signature: ____ **Date:** __________________________

Financial Policy

We would like to take this opportunity to welcome you to our offices and assure you that we will do our utmost to provide you with the best possible care.

Patients with Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier. It is your responsibility to read and understand your insurance agreement; certain services may or may not be covered, depending upon your individual policy. **Please provide current insurance information to the office, including any changes in coverage.** If your insurance carrier requires a form, please provide one to the office. We will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for payment of the bill.**

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. For example, a co-payment may be required by you as per your insurance agreement. If you are having treatment over a period of time. We appreciate payment during the course of treatment. Our Business Office will gladly assist you in arranging a payment plan. If you are unable or unwilling to accept responsibility for your account balance, please be advised that your account may be forwarded to a collection agency, which adversely affect your credit.

If you have a **High Deductible Health Plan (HDHP)**, please notify the office prior to your visit. If you have not met your deductible, we will bill you directly for any balance due. Please note, the office may request payment up front.

If you are covered through an **out-of-state insurance plan**, it is your responsibility to contact your carrier to determine if our physicians participate with your plan. Please note that these types of plans typically carry high out-of-pocket expenses.

Patients Without Insurance Coverage

Patients without insurance coverage are requested to pay for services as rendered. We accept MasterCard, Discover, Visa, American Express.

I have read and understand the Financial Policy of Your Next Step, PC

X____ ____________________
Signature of Patient or Guardian **Date**